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No. 74-1274

In the Supreme Court

of the United States

OCTOBER TERM, 1974

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

RESPONDENT'S BRIEF

ROGER TILBURY
1123 SW Yamhill Street
Portland, Oregon 97205

HENRY KANE
220 Park Plaza West
10700 SW Beaverton Highway
P. O. Box 518
Beaverton, Oregon 97005

Attorneys for Respondent

STEVENS-NESS LAW PUB. CO., PORTLAND, ORE. 9-75

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ABBOTT LABORATORIES, an Illinois corporation, et al.,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENT'S BRIEF

ISSUE ON APPEAL

Should the explicit language of the Nonprofit Institutions Act (15 U.S.C. 13c), which contains a limited exemption from the Robinson-Patman Price Discrimination Act for:

> ". . . purchases of their supplies for their own use by . . . hospitals, and charitable institutions, not operated for profit."

be tortured to include those prescription and over-the-counter drugs acquired by hospitals at lower prices than those charged drug stores, but later resold by the hospital to:

> "3. . . . in-patients as take-home prescriptions."
> "5 . . . for home treatment to out-patients either at hospital pharmacies or at out-patient clinics."
> "6 . . . to hospitals' employees and students for the private use of purchasers."
> "7 . . . to hospitals' physicians for their personal or family' use . . ."

for their private use when they return to their own homes? Some in these categories (e.g., oral contraceptives users, purchasers of vitamins, etc.) are not ill.

(Respondent is the assignor of 60 Portland, Oregon area drug stores. These are primarily small stores in urban and suburban locations. They are called community, neighborhood, or retail pharmacies or sometimes corner drug stores. We will refer to them as drug stores to distinguish them from hospital pharmacies or drug rooms. More and more the operation of hospital pharmacies resembles those of drug stores.)

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[1] See infra pp. 3-4.

SHIFT IN POSITION BY PETITIONERS

Petitioners' present stance is a sharp departure from that asserted below, where they contended 100% of all purchases by hospitals were exempt and it was immaterial what the hospitals subsequently did with them.

Evidently petitioners now concede the Court of Appeals was correct when it held that drugs sold by the hospitals under the following circumstances are not within the 13c exemption, when

> "4. They were provided to persons who had been in-patients as renewals of prescriptions which had first been filled while those persons are in-patients."
> "7. They were sold to hospitals' physicians for their . . . dispensation in the course of their private practice."
> "8. They were sold to walk-in customers who were not hospital patients."

since none of these are mentioned by petitioners.

Not mentioned by petitioners are other categories of hospital drug resale, such as:

> (a) mail order service to those who write to the hospital;
> (b) drug stores and other hospitals for further resale; and
> (c) pensioners, clergy, and in-laws of hospital employees and staff members.

ADDENDA

There is a possibility petitioners may have shifted position once more.

Petitioners' petition for certiorari at p. 7 may be interpreted as challenging that part of the Court of Appeals' ruling which held that hospital drug resales to families of staff doctors and families of employees were not within the 13c exemption. However, such sales are not discussed in petitioners' principal brief.

PRELIMINARY COMMENT

Nonissues

Respondent has never questioned the right of a hospital to sell drugs to anyone.

Nor has respondent suggested manufacturers raise their hospital selling prices, or that discounts to hospitals be ended for drugs actually used for the hospitals' "own use".

Respondent asks only that if drugs are sold to hospitals for purposes of resale, and not for the hospitals' own use, that manufacturers charge a like price to drug stores. If hospitals wish to operate as drug stores then in fairness their acquisition prices should be equalized for those items where they compete.

Parity need not mean any change in petitioners' charges to hospitals. There is every reason to believe petitioners could equalize charges to drug stores with-

out strain. Drug manufacturers' profit margins are among the highest in American industry,[2] not to mention their swollen advertising budgets.[3] Studies by the Kefauver committee reveal that if drug manufacturers were truly competitive, consumer prices could be cut "in range of 80%".[4]

The House subcommittee report on Small Business Problems in the Drug Industry" (H. R. No. 1983, 90th Cong., 2nd Sess. 79 (1968)), concluded that the

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[2] 42 Standard N.Y.S.E. Stock Reports, Standard & Poor's, 16, 126, 370, 457, 784, 1268, 1354K, 1941, 2096K, 2420.

In 229 *The Scientific American* 161 (1973) by Dr. James Goddard former chief of the FDA, states: "The pharmaceutical houses outperform all other major American industries in net profit after taxes as a percent of stockholders' equity. The drug companies regularly show a return of about 18%, a figure two-thirds higher than the average rate of return for all manufacturing concerns in the decade 1960-1970."

And (1c 163): "Year after year the industry ranks first or second in after-tax income as a percentage of net worth . . . As one economist said in testimony before the Senate Select Committee on Small Business: 'The high profitability reflects the absence of competition; the stability of profits demonstrates the absence of risk to investors.'"

In *U.S.* v. *Chas. Pfizer*, 281 F. Supp. 837 (S.D. N.Y. 1968), rev. 426 F.2d 32 (2nd Cir. 1970), affirmed by an equally divided court 404 U.S. 548 (1972), petitioner Bristol-Myers was a defendant. Production cost of tetracycline was $2.55 (1954), $1.76 (1956) and $1.59 (1958). Yet the selling price to druggists was $30.61 and $51 (R. 161).

[3] U. S. drug manufacturers annually spend $1.2 billion on the advertising and promotion of prescription drugs, nearly four times the amount spent on research and development. Prescription drugs (unlike over-the-counter drugs) advertising and promotion is confined to physicians and occasionally, pharmacists. This is approximately $4000 per doctor per year. This includes the salaries of over 21,000 detail men, each of whom costs the industry $35,000 per year. 229 *The Scientific American* 161, 162 (1973).

[4] *Small Business Problems in the Drug Industry*, Hearings before the Subcommittee on Regulatory Agencies, House of Representatives, 90th Congress, 1st Sess. 197 (1967).

"Sheer magnitude of the price discriminations evident from the record of these hearings would seem to justify vigorous remedial action by the Federal Trade Commission. It is unreasonable to expect the remedy of private anti-trust enforcement by disfavored retail druggists to serve as a sufficient deterrent to drug manufacturers' discriminatory pricing.

"It should be made absolutely clear at this point that the findings of the subcommittee, which have just been stated in no way lead to the conclusion that the solution to the problems raised is to increase the costs to institutional customers to the level of the present costs of retailers. The public interest requires, rather, that the often excessive gap between prices to wholesalers and retailers on the one hand, and institutional customers on the other, should be closed by lowering the price to retailers. Only in this way can those members of the public requiring drugs for the preservation of their health and, indeed, for their very life, buy at prices which do not discriminate against them."

No one has suggested that hospitals curtail their sales to employees, staff, inpatients, outpatients, or the public at large. Respondent's assignors are prepared to meet fair competition providing they can buy at a nondiscriminatory price.

Likewise we have no quarrel if hospitals decide to sell drugs to its staff or employees as a fringe benefit. Such decisions are for the hospital alone. But, respondent does object when the hospital is permitted to buy the same item for much less when it is not

intended for hospital use and consumption but for the private use at home of employees, physicians, families, friends, in-laws, and walk-in strangers.

Respondent has no quarrel whatever with hospitals, but rather with the source of the unwarranted discrimination—the petitioners.

There should be little effect on hospitals, since, as the Court of Appeals noted (Pet. Cert. A6):

> "in-patient and emergency treatment, cover by far the greater part of hospital distribution"

and both are within the 13c exemption (A7).

It Would be Premature to Decide the Issue Finally at this Juncture

The District Court granted summary judgment though respondent had been denied access to many critical facts. Respondent was not permitted to propound interrogatories, requests for admission, motions to produce, or take petitioners' depositions, before the court granted summary judgment.[5] The court even declined—for a time—to enter an order prohibiting documents destruction.[6] The information we did extract came, in the main, from reluctant hospital employees, several of whom were represented by petitioners' attorneys.[7] Even after the order was en-

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[5] R. 46, 126, 276, 282, 311, 322, 325, 326, 328, 339, 340, 361, 372, 373, 374, 425, 427, 438, 439, 440, 442, 450, 454, 461, 465, 471, 502, 506, 544, 552, 555, 556, 641, 700, 701, 702, 728, 842, 937; Tr. 9/11/72 p. 115, lines 16-19, and pp. 118-119; Tr. 11/27/72, p. 21, lines 6-25; p. 22, 1-3.

[6] R. 266.

[7] R. 833.

tered, many petitioners did not notify their employees.[8] Consequently, many documents were destroyed before respondent could see them.[9] Even for the hospital deposed, respondent was foreclosed from several subjects, such as the extent hospitals did ship drugs out of state to undisclosed buyers.[10]

The District Court has not yet permitted respondent to determine if the Sherman Act has also been transgressed.[11] Hence respondent's factual statement here is necessarily foreshortened.

Summary judgment is inappropriate where there are a plethora of material fact disputes as here. Respondent submitted numerous personal knowledge affidavits challenging Petitioners' data.

Petitioners did not challenge respondent's affidavits or submit affidavits or evidence of its own.

Hurtado v. *United States*, 410 U.S. 578, 587-588, fn. 8 (1973) held summary judgment was improper where the government did not support its Answer with affidavits or other evidence.

As in *Adickes* v. *S. H. Kress Company*, 398 U.S. 144, 157 (1970) petitioners failed to show the absence of a genuine issue for the material issues raised by respondent's affidavits.[12]

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[8] Krieger 5, 6; Mason 6, 7; Metz 63; Coffee 5, 7; Connerty 9; Duley 6.

[9] McClintic 75; Mason 6; Metz 97, 109; Coffee 7.

[10] Pirtle 35.

[11] R. 46.

[12] *Arnett* v. *Kennedy*, 416 U.S. 134, 139 (1974) states:

". . . Since the District Court granted summary judgment to appellee, it was required to resolve all genuine disputes as to any material facts in favor of appellant, and we therefore take as true for purposes of this opinion the material particulars of appellee's conduct which were set forth. . . ."

Court of Appeals Decision Misconstrued by Petitioners

Petitioners have misread the Court of Appeals opinion. They have assumed that when the Court held the 13c exemption included inpatients and emergency patients, the court used the word "inpatient" in the most constricted sense.

The terms 'inpatient' and 'outpatient' have different meanings to different hospital administrators.[13]

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[13] Compare the depositions of the following hospital personnel:

Ammon, 6, 8, 10, 19, 20; Bleckinger, 10; Camosso, 6, 36, 42; DeLorimer, 7, 8, 13; Desrosiers, 6; Eldien, 12; Fraser, 4, 5; Graham, 35; Haas, 13; Hanson, 7, 8; Hastings, 9, 10; Hollowell, 7; Johnston, 33; Kaeser, 6; Lindley, 5; Pirtle, 16, 49; Renfrow, 22; Scott (1st), 47; Schulte, 8, 13; Sessler, 4; Shupe, 9, 23; Slick, 10; Smith, 11, 12, 13; Sperry, 7, 8, 13; Steed, 9; Walker, 6, 8; Underriner 4; Wong, 8, 24, 26; Zeasas, 26, 28.

Whether a patient must occupy a bed and/or receive meals at the hospital or stay overnight is a matter of debate between various hospital personnel. Paul Hanson, administrator of one of Portland's principal hospitals, feels that one admitted for day surgery who does not remain overnight, is an inpatient (Hanson, 7, 10). The Chief Pharmacist at another hospital felt that admission for one night was a sine qua non (Bleckinger, 10, 11). Another believed those using the outpatient clinic were inpatients (Camosso, 42). Many hospitals have nothing in writing which spells out the distinction (Schulte, 13; Scott (1st), 47; Sperry, 13). Two hospital officials felt confused (Fraser, 4; Pirtle, 16), while a third was not permitted to answer by his attorney (Zeasas, 26, 28). A fourth felt a stay of more than 12 hours was necessary (Schulte, 8).

Some hospitals regard emergency room patients as inpatients — others do not (Underriner, 4; Pirtle, 16; Shupe, 9; Walker, 6).

The Health Insurance Manual issued by the Department

Even lexicographers seem unable to agree completely.[14]

The Court of Appeals' well reasoned opinion has adopted a rational and pragmatic standard, which can be applied and understood with ease. A careful reading reveals that the court did not hold that all outpatient sales were outside 13c. Rather only those where (Pet. A5):

> "5. They were sold *for home treatment* to outpatients either at hospital pharmacies or at outpatient clinics." (italics supplied)

Thus drugs administered to patients in the hospital or hospital clinics (such as injections or drugs) were covered by the 13c exemption irrespective of the way in which the particular hospital classified such individuals. This is made clear by the court's further statement (Pet. A6):

"There is no dispute that such dispensing of

of Health, Education & Welfare 210 (10-71) regards as an inpatient one who is "formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight. However, there are exceptions to the general rule:

> A. Hospitalization for Minor Surgery—When a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him in the hospital for only a few hours (less than 24), and this expectation is realized, he will be considered an outpatient regardless of: the hour of admission, whether or not he used a bed, and whether or not he remained in the hospital past midnight."

[14] Compare *Webster's Third New International Dictionary*, Unabr. with *Brittanica World Language Dictionary*, and Smith deposition 12.

> drugs in the course of treatment in the hospital is the hospitals' own use."

We agree. A use in the hospital under hospital auspices of a drug acquired by an individual, whether called an outpatient, inpatient or whatever is a use by the hospital. However, a drug purchased from the hospital pharmacy for use outside the hospital by one who is no longer a patient or who never was, cannot logically be regarded by the hospital as "their supplies for their own use".

Petitioners somewhat facetiously (we suspect) insist the Court of Appeals drew the line between an exempt and non-exempt sale on the basis of the angle of the patient receiving the drug. Nothing in the opinion supports this. The opinion makes it very clear it does not matter in the least whether the individual receiving the drug is horizontal, vertical, or diagonal. Neither does it matter whether the patient is occupying a bed or not. No such naiveté can fairly be imputed to the court. Rather the distinction, which the court drew, is the one drawn by the law itself (i.e., "their supplies for their own use"). A day surgery patient receiving medication while being treated in the hospital would be covered whether in bed or not, as would one receiving a shot or pill while standing upright or otherwise in the outpatient clinic, but not one who receives a package of oral contraceptives for use at home.

STATEMENT OF FACTS

A. Discrimination by Petitioners against Drug Stores

The pharmaceutical industry has long been characterized by high concentration, high advertising cost, intense nonprice competition,[15] cross licensing and sales,[16] and frequent absence of meaningful price competition.[17]

Concomitantly, the drug manufacturers (petitioners included) have long discriminated against the generally hapless drug stores and in favor of virtually every other trade and pressure group, and especially hospitals.[18] The motivation for favoring hospitals is apparently to acquaint physicians (especially neophytes) with brand names so they will subsequently prescribe such drugs by brand rather than generically,[19] even though this may ultimately cost the patient double, treble or more.[20]

[15] Department of Health, Education and Welfare, *A Report to the President* 37 (February 1967).

[16] R. 133.

[17] See Appendix A containing (inter alia) excerpts from the hearing on the small Business Problems in the Drug Industry by the House Subcommittee on Activities of Regulatory Agencies, which concluded (H.R. 1983 (1968), p. 77): "There is little or no price competition in the marketing of trademarked pharmaceutical products among manufacturers." Hereafter for brevity, respondent will refer to this hearing as Hearings unless otherwise marked.

In his book "In a Few Hands" 8-10 (1965) Senator Kefauver stated: "Perhaps no more dramatic illustration of the effect of monopoly on the consumer can be found than in the drug industry . . . In the various categories of drugs examined by the Subcommittee, prices of the major companies were identical, often to the last decimal . . .

". . . most drugs are actually manufactured and sold in bulk form by two or three producers — sometimes only one. All companies, large or small, that market the product buy the drug in bulk form from these sources."

[18] See pp. 14-16, infra.

Witnesses before the Subcommittee to the Select Committee on Small Business of the House of Representatives described the variegated pricing modes of drug manufacturers as chaotic,[21] startling,[22] and rampant with "wheeling and dealing".[23] Another long time wholesaler told the committee (1c 297):

> "I know of no other business that has so many different prices. I know of no other business where the cost of raw material is so negligible in relationship to the selling price of the finished product."

The final report of the Subcommittee of the House of Representatives contained the following chart (H. R. No. 1983, 90th Cong, 2d Sess, 10):

[19] Hearings, Ibid., p. 43; House Report 1983, 90th Congress, 2nd Session, 10, 19, 34, 37, 67, 68; Connerty deposition, 17, 20.

[20] Hearings, Ibid., 50 (even a ten-fold variation at times), 151, 269, 279, 298 ('if you take certain trademark drugs, . . ., the one that sells at $22.60 is commonly sold under its generic name for anywhere from 75 cents to $1.25'); 411 (on occasions the same manufacturer will produce the same drug under generic labels to compete with its own brand name product).

Despite the inanity of ordering the identical product by its brand name, instead of generically, when the comparative cost may be far higher, roughly 90% of the drugs are prescribed by brand names (Ibid. 277).

[21] Hearings, supra 260.

[22] Report of the same committee, H.R. No. 1983, p. 31.

[23] Ibid., p. 317.

COMPARATIVE PRICES CHARGED HOSPITALS AND RETAIL DRUGGISTS

Drug	Quantity	Price to Hospitals	Price to Druggists
Amphycillin	100	$11.96	$27.25
Dilantin	1000	7.00	9.30
Diuril	1000	30.00	48.45
Equanil	500	11.30	29.00
Gantrisin	1000	9.00	29.30
Ilosone	100	16.64	21.99
Librium	500	23.95	27.75
Melleril	100	6.40	7.50
Neomycin	100	5.20	20.54
Notec	100	2.00	4.08
Peritrate	500	25.50	30.00
Steclin	100	4.95	5.50

Other of discriminations appear in Appendix B. Doubtless still others could be uncovered if we are given an opportunity. Though this case has been pending more than four years, respondent has not yet been permitted to ask petitioners or the hospitals what prices were charged the nonprofit hospitals. (See supra, p. 7).

In addition some petitioners discriminated against drug stores in favor of hospitals in the following respects:

(a) free goods;[24]

(b) 'hospital size' packages of drugs (some at

[24] Hearings, supra, 71, 86, 129, 136, 143 ("unequivocally"); Connerty, 20, 26; DeLong 55; Duley (1st), 37 (though sometimes called, euphemistically, "starter dose(s)"), Krieger, 11, 12 (though some manufacturers prefer to refer to such free goods as gifts to the doctors in the hospital, rather than gifts to hospital doctors); Metz, 17, 50, 103.

considerable savings) are made available to hospitals and to no one else;[25]

(c) some items are sold only to hospitals, but not drug stores;[26]

(d) quantity purchase ceilings are sometimes imposed on drug stores (or on wholesalers through whom they must sometimes buy), but not hospitals;[27]

(e) some petitioners refuse direct sales to drug stores, but not hospitals;[28]

(f) quantity discounts ostensibly do not favor hospitals, but practically speaking do because they are often out of the practical reach of drug stores.[29]

[25] Hearings, supra, 64, 248, 274, 286; R. 132, 147; House Report No. 1983, 90th Cong., 2d Sess. 7, 11, 34, 39; Connerty, 19, 21, 36, 46, 52; Duley, 78, 80; Krieger, 61, 64, 67, 74.

[26] Hearings, supra, 111; R. 136; House Report No. 1983, 90th Cong, 2d Sess 18, 19 ("A community pharmacy that is unable to buy certain products, it seems, is placed at a great competitive disadvantage with one that is not so restricted").

[27] Hearings, supra, 201, 219, 321; House Report No. 1983, 90th Cong. 2d Sess. 23, 38; Connerty, 48, 49, 50, 51.

[28] Hearings, supra, 74, 111, 142, 143, 273; R. 105-6, 123, 143, 292, 377; House Report No. 1983, 90th Cong, 2d Sess, 59; Connerty 45; DeLong 88; Hannon, 11, 24; McConnell, 9, 10, 12; Mason 11; Winther 4; Zeasas 14.

[29] Hearings, supra, 72, 315, 516; House Report No. 1983, 90th Cong, 2d Sess 50, 54, 55 (committee counsel observed "that the mommas and poppas of the industry cannot afford to start 5 or 10% behind Mr. Dart and Mr. Drug Fair and Mr. Peoples and hope to survive". This remark is also applicable to hospital competition too); Clifford, 13, 20, 23 (such quantity discounts do not appear in the Lilly catalogue, and would not be shown to a neighborhood pharmacy unless there were a special request); Coffee, 57, 59, 67; DeLong, 66, 67, 70; Duley (1st) 47; Kobelin 29; Kreiger, 50, 61

(g) handling charges are imposed at times on drug stores but not hospitals;[30]

(h) drug stores are not always permitted to buy the more popular brands;[31]

(i) extra time for payment is granted by petitioner Warner to direct purchasing hospitals, but not drug stores.[32]

There is little indication petitioners make the slightest effort—or cared—what disposition hospitals made of the drugs. Some—such as oral contraceptives—were patently never intended for use or consumption within the hospital.[33]

B. Aftermath of Hospital Discrimination

Having acquired the drugs under 13c at substantial discounts, ostensibly for "their own use", the favored Portland hospitals soon began sales for consumption or resale outside the hospitals to one or more of the following:

(a) employees and their families, parents, and even in-laws.[34]

(hospital package quantity price is not listed in Warner's retail pharmacy pricelist for September 1974 since this is a special hospital packet available for hospital use only); Metz 19 (discount quotations were not offered by Bristol to neighborhood pharmacies but only to hospitals), 36-38.

[30] R. 730.

[31] House Report No. 1983, 90th Cong, 2d Sess 18.

[32] Ibid 36, 37.

[33] Ibid 43.

[34] R. 794, 221, 222, 223, 263, 298, 319, 457, Ammon 18; Camosso, 26, 30, 21; Chartier, 7, 8; DeLorimer 16; Desrosiers, 10, 11, 13; Eldien 5; Fawkes (1st) 24, 26, 38; Ferrell 7; Fraser 10; Graham 21; Hollowell, 7, 8, 15, 16, 19; Johnston, 4, 19, 21, 22; Kaeser, 5, 31, 33, 37, 43; Matlick, 8, 9, 11; Neal 4; Renfrow 15; Schulte 12; Sessler 8; Kaeser 50; Lindley, 6, 8, 9-11; McConnell, 17, 24, 29, 32; Mack, 9, 11; Shupe, 5, 11, 28, 29, 32; Slick, 12, 17, 18; Smith 18; Sperry 8; Steed, 7, 12; Stocks, 6, 9; Wong, 9, 11, 20; Zeasas, 17, 18, 21.

(b) staff doctors for their personal, family, and office use;[35]

(c) volunteers, students, pensioners and clergy;[36]

(d) take-home drugs (also called, "Go Home Meds") to patients upon discharge for use at home;[37]

(e) walk-in individuals, who had no connection with the hospital;[38]

[35] R. 398, 419; Ammon, 18, 20; Bremner 11; Eldien, 5, 12; Fawkes (1st) 4, 23, 26; Fawkes (2nd) 29; Graham 21; Haas, 8, 16; Hastings 20; Hollowell, 7, 8; Johnston 4; Matlick 9; Sessler 8; Lindley 11; McConnell 24; Smith 18; Sperry 8; Steed 12.

[36] R. 795, 398, 419; Ammon 20; Fawkes (2nd) 29, 30; Kaeser 35; Zeasas 21.

[37] R. 398, 420, 455, 456, 471, 472, 643, 645, 711, 713, 791, 792; Ammon, 23, 25; Chartier, 5, 6, 11, 18, 19; DeLorimer 13; Eldien, 11, 12, 14; Fawkes (1st) 19; Gustafson 16; Haas, 7, 8, 17, 19; Hastings, 13, 15; Kaeser, 6, 44; McConnell, 23, 24, 37; Matlick, 13, 14; Neal, 4, 9; Pirtle 14; Renfrow 8; Schulte, 19, 20; Sessler, 7, 11; Shupe, 29; Slick 20, Smith, 13, 15; Walker, 15; Wong, 7; Zeasas, 15, 18.

[38] Hearings, Small Business Problems in the Drug Industry, Subcommittee on Activities of Regulatory Agencies of the Select Committee on Small Business, House of Representatives, 90th Cong, 1st Sess. 24, 138; R. 126, 345, 378, 458, 460, 461, 476, 645, 940; Bremner, 9, 26; Camosso, 6; Fawkes (1st) 4, 9, 26, 33; Fawkes (2nd) 30; Graham, 28, 55 (somewhat higher sales during fishing season, of seasick pills); Gustafson, 6; Haas, 9; Kaeser, 5, 6, 15, 35, 44; Lindley, 6, 8, 13 (not to his knowledge has a pharmacist at North Clackamas Hospital ever refused to fill a prescription that is legitimate to the general public); McConnell, 20, 23 (no restrictions on over-the-counter drugs), 44; Mack, 10 (there is no policy at Gresham Hospital prohibiting the general public from the hospital pharmacy); Sessler, 5, 6, 12, 19; Walker, 9; Wong, 20; Zeazas, 4, 15.

(f) as refills of those prescriptions covered by (a), (b), (c), (d) and (e) above;[39]

(g) to other hospitals, clinics and even drug stores;[40]

(h) mail order sales to those writing the hospital from their homes;[41]

(i) to all members of a particular union and without limit, and whether ill or otherwise.[42]

C. Extent of Hospital Resales to Nonhospitalized Individuals is Huge, and Easy to Determine

At various times petitioners have disavowed any reliance on the de minimis defense.[43] However, since they seem to have resurrected it here, it should be stressed that the quantum of sales to nonhospitalized individuals for use at locations remote from the hospital was immense.

It is relatively easy to determine the numbers.

"Prescription" refers only to drugs not intended to be used within the hospital.[44]

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[39] R. 332, 891, 938, 941; Camosso, 12, 13; Graham, 27; Haas, 15, 16; Pirtle, 15, 40 (the refill ratio has been approximately 40%); Winther, 10.

[40] Bremner, 21; Chartier, 15; Gustafson, 4; Haas, 14; McConnell, 29; Metz, 3, 74, 75, 77, 78, 80; Pirtle, 21, 22; Desrosiers, 13; Eldien, 7; Fawkes (1st) 15, 16; Fawkes (2nd) 8; Graham, 43; Haas, 14; Johnston, 18; Kaeser, 50; Zeasas, 20.

[41] Greenlick dep. ex. no. 3, Johnson and Christensen, *A Report of the Kaiser Foundation Drug System* (1971) 299.

[42] R. 369, 470; Ferrell, 11; Swope, 3 (Local 1092, Retail Clerks, is under such an agreement. It has just under 7,000 members, making it the largest local in Oregon).

[43] R. 797, 833.

[44] Or. Rev. St. 689.010(3) and (5); 689.170; 689.825; Zeasas, 9; Fawkes (2nd) 15; Shupe, 5.

All drugs leaving the hospital must have a prescription number and be filled by a licensed pharmacits.[45] Prescription refers to a drug used by one no longer a hospital patient or who was never a patient, for consumption at a location other than the hospital.[46] A drug given to a patient in the hospital is called a 'hospital order'.[47]

The extent of sales to nonpatients is substantial.

One hospital in Portland to whom petitioners made discriminatory sales filled 216,958 prescriptions for nonhospitalized individuals between December 26, 1967 and May 8, 1973.[48] Another, 231,061 between July 1, 1970 and April 12, 1973. A third filled 49,435 new prescriptions between March 29, 1969 and March 16, 1973. A fifth, 38,045 between March 15, 1971 and March 9, 1973. A sixth, 17,803 between February 2, 1971 and February 2, 1973.[49] At another hospital the numbers of prescriptions (which necessarily means the individual is not or was never a patient) were (R. 272):

3/1/70 to 12/31/70	279,151 prescriptions
1/1/71 to 12/31/71	409,790 prescriptions
1/1/72 to 9/30/72	343,626 prescriptions

Furthermore, there is reason to believe the extent of hospital sales to those who are not — or never were — hospital patients is larger than conceded. An in-

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[45] Ibid. R. 716.

[46] Ibid. Fawkes (2nd) 15; Shupe, 5.

[47] Ibid.

[48] R. 832.

[49] R. 744, 746, 897.

vestigator was able to make purchases of prescription drugs at eight of the fourteen Portland area hospitals without difficulty though not a patient or ill, despite their subsequent denials.[50]

Not infrequently petitioners charge wholesalers more than they charge hospitals.[51] Despite this, some petitioners still insist that drug stores buy through wholesalers and not direct.[52] To exacerbate matters, most pharmaceutical manufacturers recently cut discounts to wholesalers, thus virtually mandating a raise in their selling prices to drug stores.[53]

The hospital generally resell the drugs to their own officers, employees and staff doctors at lower

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[50] R. 343-347.

[51] Hearings, Small Business Problems in the Drug Industry, House of Rep 90th Cong, 1st Sess, Subcommittee on Activities of Regulatory Agencies 248 (Jack Mandell, one of New York's largest wholesalers, testified: "it is prevalent in the drug industry, by some manufacturers, to sell to hospitals at prices far below what a wholesaler will buy it at.")

See also: R. 308 (Robins sells to wholesalers at discounts of 16-2/3% and to non-profit hospitals at a 20% discount); Coffee, 41, 59; DeLong, 60; Koss, 8; McClintic, 36; see also Connerty, 38; H. R. No. 1983, 90th Cong, 2d Sess, 9 ("The subcommittee received testimony to the effect that drug manufacturers sell their product to hospitals at phenomenally low prices which are often below cost. A witness cited the following specific example: A pharmacist who wants to buy a bottle of 500 Equanil tablets, which is a trade name for meprobamate, 400 milligram tablets, will pay *$29 for the 500*. Hospitals are in a position to buy this product in units of a *thousand* tablets to the bottle for *$22.60")*. The report also quoted (1c 9) from the *Indiana Pharmacist* of December 1965 as follows: "There seems to be universal agreement that the pricing system currently in use by most of the pharmaceutical manufacturers is often inconsistent, unfair, and generally chaotic."

[52] Footnote 26.

[53] Hearings, supra, 296.

prices than those charged hospitalized patients.[54]

Fourteen Portland hospitals have more than 10,000 employees,[55] not including their families. There were 2,500,000 plus full-time hospital employees nationally in 1971.[56]

Not infrequently a higher price was charged inpatients than that charged outpatients or off-the-street customers.[57] Thus, hospitals were able to mark up the price and generate substantial profits, and still resell to nonhospitalized persons at lower prices

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[54] R. 113, 398, 550; Camosso, 32, 33; Chartier, 10; DeLorimer, 16; Desrosiers, 10, 11, 13; Eldien, 5; Fawkes (1st) 23; Graham, 21; Gustafson, 4; Haas, 8, 21; Hanson, 11; Johnston, 19, 21; Kaeser, 30, 33, 37; Matlick, 11, 15, 18, 19; Neal, 4; Renfrow, 15; Schulte, 12; Sessler, 8; Lindley, 9, 11; McConnell, 17, 29; Mack, 9; Wong, 11; Zeasas, 21.

[55] Stocks, 10.

[56] Knowles, The Hospital, *Scientific American* (Sept. 1973), 128, 133.

[57] Chartier, 8; Eldien, 9-10; Ferrell, 8; Pirtle, 18; Ibid., fn. 41.

As explained to the House Committee by Edward Bopp, president of the Louisiana Pharmaceutical Association (Hearings, supra 141):

> "Gentlemen, you can readily understand the unfair disadvantage a drugstore retailer occupies in competing with a dispensing pharmacy and hospital-clinic purchasing the same merchandise at 15 to 20% less than can be purchased by said retailer. The general pricing practice of hospital-clinics may be to mark prescription drugs from cost indicating the retail community pharmacy is being markedly undersold. Therefore, you procure a bad image in said community and are identified as a commercial profiteer steadily forefeiting consumer business."

As he further explained (1c 139):

> "In the case of outpatients, their prices must be competitive with the druggists, but with the captive audience, the inpatients, they do not have competition."

than drug stores must charge to economically survive.[58]

In the meantime, the drug store pharmacist, who is struggling to survive but is treated by petitioners as the industry wallydrags, is made to look bad because there is no way he can match the prices charged by the favored hospital pharmacy to outpatients and casual drop-ins. As explained to the House committee by Hyman Moore, a major drug wholesaler (Hearings, supra 318-319):

> "There is something available to everybody I can think of to get a good price on their merchandise except the average corner pharmacist. He is the one who is being made to look like the price gouger and it is not so. There are just darned few rich retail druggists."

D. Effect of Discriminatory Pricing has been Disastrous to Drug Stores

Armed with the leverage of discriminatory prices, the inevitable occurred. In opening the Congressional hearing, Chairman Dingell observed (Hearings, supra, 1st Sess (1967), p. 1):

> "In the distribution of drugs, however, the small business wholesaler and particularly the retailer contribute much to the task of insuring ready access by all our people to their lifegiving products.

[58] Ibid; Hearings, supra 137 (markups as high as 800% were described to the committee) R. 456, 484; Desrosiers, 22, 23; Fawkes (1st) 13; Haas, 6; Hollowell, 16-17; Kaeser, 28, 30; McConnell, 29, 31; Matlick, 15; Pirtle, 31; Renfrow, 47; Shupe, 14, 17; Sperry, 9; Winther, 7; Zeasas, 13.

> "In recent years there has been a continuing decline, both in market share, as well as actual numbers, in the independent sector of the industry."

While hospital drug sales have increased steadily (see chart at back of brief), the ranks of the drug stores have been correspondingly thinned, and their net profit margins have been eroding for years.[59] At the same time manufacturers' sales and profits have grown with almost monotonous regularity.[60]

As stated in the final report of the House subcommittee:[61]

> ". . . there is here something of a paradox that manufacturers' profits should be at an alltime high while wholesalers' and retailers' profits are declining—that the public's cost for drugs has more than doubled per prescription and has increased more than sixfold in terms of dollar volume—yet, retailers report that they are all too often encountering problems in terms of profitability."

In Portland more than half the drug stores have closed within the past ten years.[62] Concomitantly hos-

[59] H.R. 1983, 90th Cong, 2d Sess. 40-41 (1968).
[60] Ibid, 41.
[61] Ibid.
[62] The closures of neighborhood drugstores in Portland from 1954-1972 are as follows (R. 541): 1954—2; 1955—1; 1956—0; 1957—2; 1958—0; 1959—0; 1961—4; 1962—1; 1963—8; 1964—2; 1965—7; 1966—8; 1967—8; 1969—6; 1970—11; 1971—7; 1972—7.
Inadvertently omitted was 1968 from R. 541. However, the correct number was 5 closures in 1968. (Plaintiff's Sept. 15, 1975 certificate in support of amended complaint filed in the district court).

pital sales have boomed.[63] The points of closure are also revealing. The locations most acutely affected are those closest to the hospitals as reflected in the three maps in the folder at the back of this brief. Even more abysmal are the prospects ahead for drug stores unless the Robinson-Patman Act is enforced. Portland's Kaiser Hospital has made a projection of

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The rate of attrition of neighborhood pharmacies appears to be a national phenomena as well. Testimony before the House Committee revealed that (H.R. No. 1983), 90th Cong, 2d Sess.):

(a) in Philadelphia there were 1400 drugstores owned by pharmacists in 1945. In 1967 there were only 800, and it was predicted that the number could contract further to 700 or perhaps even 500 (1c 11);

(b) in Maryland 8 independent drugstores were forced to close their doors in the three months prior to the hearing in 1967 (1c 17);

(c) in the Bronx during a 10-12 year span, the number of drugstores has declined from 600 to 400 or so. (Hearings, supra, 160, 185);

(d) in Massachusetts during a ten-year period 100 neighborhood pharmacies have closed (Hearings, supra, 60).

An article in The Oregonian (Sept. 16, 1975, p. B-2) states that "Illinois has been losing 30 pharmacies a year for 10 years."

[63] Drug sales at the various Portland hospitals which have been mentioned have grown from $568,871 (1966) to $881,880 (1971) at Emanuel; from $518,748 (1967) to $885,562 (1972) at Good Samaritan; from $247,754 (1967) to $318,337 (1972) at Holladay Park; from $238,466 (1967) to $389,862 (1972) at Physicians and Surgeons; from $322,157 (1966) to $492,550 at Portland Adventist; from $197,900 (1967) to $245,762 (1971) at Portland Osteopathic; from $339,678 (1966) to $640,286 (1971) at Providence; from $419,815 (1966) to $630,282 at St. Vincent; from $62,590 (1966) to $295,275 (1972) at Tuality Community; from $54,007 (1965) to $263,274 (1972) at Willamette Falls; from $36,211 (1967) to $69,944 (1972) at Willamette Methodist; and from $250,720 to $1,447,575 (1971) at Bess Kaiser (R. 866-7 and chart infra). (Earlier figures were not available for the other two hospitals.)

its future drug sales. Its study revealed sales of 57,100 prescriptions in 1960 and 315,100 in 1969. It anticipates 1980 sales of 590,000, if all other factors remained fairly constant.[64] Using more optimistic projections the total is 744,000-779,100.[65] If the "capture rate" (Kaiser's term for the percentage of patients who consulted Kaiser doctors, who had their prescription filled at the Kaiser Hospital pharmacy) were to be raised to 100%, then Kaiser estimates sales for 1980 of 1,682,000 prescriptions.[66] If Kaiser succeeds in this even partially, there will be few sales left for the drug stores.[67]

E. Simultaneously Profit Margins have been Substantial at Hospital Pharmacies

While Portland's drug stores have been decimated, net drug profit margins at 12 of Portland's 14 hospitals have varied from 28.8-60.53% (R. 444).[68]

F. The Extent of the Problem is Intensifying. Hospital Resales to Nonpatients are Capturing Larger and Larger Market Share.

Certain demographic trends have also been noted

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[64] Ibid., Fn. 41.

[65] Ibid., 193-195.

[66] Ibid., 198A. (An increase in the "capture rate" is apparently a primary desideratum of Kaiser, if one can read between the lines of this survey).

[67] Illustrative of the impact of an additional 275,000-1,300,000 sales by Kaiser Hospital, might be seen in the sales of the Bel Aire Pharmacy, a typical Portland pharmacy and one of the assignors. In thirteen months Bel Aire filled 9,826 new prescriptions, an average of 756 per month (R. 543).

[68] The profit margin at the 13th was 9.85%, while the 14th did not have the figures (R. 444).

nationally, though not all have yet impacted on the Portland area:

(a) emergency rooms often serve the same function as doctors' offices (especially on the weekends when many doctors cannot be reached) for nonacute medical care;[69]

(b) more and more doctors have moved their offices closer to or into the hospital. Many of their nonhospitalized patients obtain their prescriptions at the hospital pharmacy;[70]

(c) several hospitals have amalgamated some or all of their operations, while others have merged altogether;[71]

(d) some hospital pharmacies are now operated by concessionaires, including chain stores in some parts of the U.S.,[72] (though not in Portland as yet);

(e) satellite clinics have been opened by several hospitals at locations remote from the hospital. Some of these (including Kaiser) have offices for physicians but no beds for patients;[73]

(f) hospitals have been filling larger and larger

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[69] Bodenheimer, Patterns of Am. Amb. Care, *VII Inquiry* 26, 33, (Sept. 70).

[70] R. 132, 547, 653; House Report No. 1983, 90th Cong., 2d Sess. 34, 47; Chartier, 10; Smith, 19.

[71] Brodie & Graber, Institutional Pharmacy Practice in the 1970's, *28 Am Journal of Hospital Pharmacy* (1971) 240, 241; Camosso, 3.

[72] Hearings, supra 13. (In Los Angeles, Daylin, Inc., a large retail drug discount chain has plans to take over pharmacies at Doctors Hospital, Westside Hospital, and Hawthorne Memorial Hospital); Brodie & Graber, Institutional Pharmacy Practice in the 1970's, *28 Am. Journal of Hospital Pharmacy* (1971) 241.

[73] Brodie & Graber, supra, 241.

percentages of prescriptions as compared with neighborhood pharmacies.[74]

SUMMARY OF ARGUMENT

The 13c exemption is limited by its terms to purchases by nonprofit institutions, including hospitals, of "their supplies for their own use"—and should be so construed, and not judicially amended or repealed.

The 13c exemption is construed strictly. It should not be used as to destroy competition. It does not apply when a hospital uses the drugs, food, etc., acquired at discriminatory prices, for non-hospital uses.

The House Subcommittee which investigated this agrees that 13c applies only to intrahospital uses, as did the Court of Appeals.

Words are construed in their ordinary and usual sense. The word "use"—especially the words "for their own use" — refers to consumption by the hospital, and not for resale to others. "Supplies" normally connote things intended for use by the person supplied and not for a subsequent resale. 13c does not apply to purchases for subsequent resale.

Other legal authorities are in accord with the Ninth Circuit decision here.

Congressional purpose will be defeated if hospitals are permitted to obtain drugs at discriminatory prices

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[74] An article in the *American Druggist* (August 9, 1971) states that the percentage of prescriptions filled by hospitals had risen from 34% (1965) to 42% (1970) (R. 680).

for nonhospital uses. 13c was passed so that hospitals might care for charity patients in hospitals at reduced cost. Since its passage the amount of charity extended by hospitals has contracted — not expanded — to the point of extinction in some hospitals.

When 13c was passed in 1938, there were few sales by hospitals to nonhospitalized persons. Normally statutes are construed with reference to the circumstances which existed at time of passage. Statutes are not modified or repealed except by the enacting body.

Take-home drugs are not covered by 13c, since they are not intended for the hospital's own use, but for the private use of an individual at home who is no longer hospitalized.

Employee and physician drug purchases for their personal or family use at home are not supplies used by the hospital.

The standard enunciated by the Court of Appeals is logical and in keeping with the express language of 13c. It can also be administered with ease.

Drug stores should be preserved and are superior in many respects to hospital pharmacies. The consumer should be given the option.

The final destination of hospital profits from drug sales is irrelevant.

The de minimis defense cannot apply where the amounts involved are enormous, as here.

ARGUMENT

I. Construction

A. The 13c exemption is limited to purchases by nonprofit institutions of "their supplies for their own use" — and should be so construed.

Detached from the petitioners' political and sociological arguments, the basic legal issue here is not complex.

The Nonprofit Institutions Act exemption is not obscure, i.e.:

"their supplies for their own use."

Petitioners would like some language added so it would say:

"their supplies for their own use or for the private use of the hospital's employees, staff doctors, and patients (both inpatients and outpatients and their families)[75] at their respective homes."

The amicus (AHA) seeks to amend the entire Act judicially, so it would read:

"if the majority of the supplies acquired are used for hospital uses then the Robinson-Patman Antidiscrimination Act shall not apply."

AHA reiterates one phrase it wrenches out of context from *Logan Lanes, Inc.* v. *Brunswick Corp.*, 378 F.2d 212, 217 (9th Cir. 1967), viz:

"the primary purpose".

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[75] There is some doubt whether petitioners still contend families are covered by 13c. See p. 4, supra.

Acceptance of this test, in lieu of the unambiguous one used by Congress, would mean that if 51% of the supplies acquired by a hospital from a manufacturer were for hospital uses, the other 49% could be employed in any way the hospital chose. A hospital could, for example, use the other 49% to open one or more retail drugstores at a location remote from the hospital, using its discriminatory prices to slash whatever remained of the market. In fact, Portland's Kaiser Hospital is doing just that with its six clinic pharmacies scattered throughout the Portland area miles from the hospital in many cases. They sell indiscriminately to one and all.[76] It is not even necessary to be a Kaiser member to buy at thees pharmacies.[77]

B. § 13c construed strictly and to protect competition.

The antitrust laws, and the Robinson-Patman Act in particular, are construed broadly, while exemptions are construed strictly and in favor of competition. *Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1963); *Perkins* v. *Standard Oil Company of California*, 395 U.S. 642, 647 (1969); *U. S.* v. *McKesson and Robbins*, 351 U.S. 305, 316 (1956).

The Robinson-Patman Act was enacted in 1936 to curb and prohibit all devices by which larger buyers gained discriminatory preferences over smaller ones by virtue of their greater purchasing power. *Federal*

[76] R. 274, 456, 478, 481, 538.
[77] Ibid.

Trade Commission v. *Fred Meyer, Inc.*, 390 U.S. 341, 349 (1968).

The Act is remedial. Such statutes are broadly and liberally construed to effectuate their purposes. *Peyton* v. *Rowe*, 391 U.S. 54, 65 (1968); *Tcherepnin* v. *Knight*, 389 U.S. 332, 336 (1967).

Antitrust immunity is not favored, (*United States v. National Association of Securities Dealers, Inc.*, — U.S. —, 95 S. Ct. 2427, 2443 (1975)) or lightly implied. *United States* v. *First National City Bank of Houston*, 386 U.S. 361, 368 (1967); *Goldfarb* v. *Virginia State Bar*, — U.S. —, 95 S. Ct. 2004, 2013 (1975).

In the absence of an unmistakable directive, the Court has refused to construe legislation aimed to protect a certain class in a fashion that contravenes the goals Congress clearly intended. *NLRB* v. *Plasterers' Local Union No. 79*, 404 U.S. 116, 130 (1971); *FTC* v. *Fred Meyer, Inc.*, supra, 1c 349.

The § 13c exemption is to be read in harmony with the purpose of the Robinson-Patman Act and to extend only to practices plainly within the exemption. *McDonald* v. *Thompson*, 305 U.S. 263, 266 (1938).

Like other excepting clauses, it is to be narrowly construed. *United States* v. *Scharton*, 285 U.S. 518, 521-522 (1932); and *Piedmont & Northern Railway Co.* v. *I.C.C.*, 286 U.S. 299, 311, 312 (1932).

Section 13c should not be read in isolation. In expounding a statute the Court is not guided by a single

sentence or part of a sentence, but rather the whole law, its object and policy. *Philbrook* v. *Glodgett*, — U.S. —, 95 S. Ct. 1893, 1898 (1975).

In construing an exception to a general statute, any doubt is to be resolved in favor of the general provisions, rather than the exceptions. *State* v. *Wright*, 84 Wash. 2d 645, 529 P.2d 453, 458 (1974).

Section 13c is an express exemption for a hospital's 'own use', hence an additional expanded exemption by implication for 'resale' is not favored. As stated in *Colorado Public Interest Research Group, Inc.* v. *Train*, 507 F.2d 743, 747 (10th Cir. 1974), cert. granted June 2, 1975:

> ". . . where the legislature has acted to except certain categories from the operation of a particular law, it is to be presumed that the legislature in its exceptions intended to go only as far as it did, and that additional exceptions are not warranted."

Section 13c uses a combination of finely honed words evidencing a legislative intent to restrict the exemption. The court must give effect, if possible, to every word of the exemption. *United States* v. *Menasche*, 348 U.S. 528, 538-9 (1955).

Congress is presumed to have used no superfluous words and courts are to accord a meaning, if possible, to each word used. *Platt* v. *Union Pacific R.R. Company*, 99 U.S. 48, 58 (1879).

Hospitals that resell drugs for off-premises consumption are competing with drug stores at the

same functional level. *United States v. McKesson and Robbins, Inc.*, 351 U.S. 305, 313 (1956).

Drug sales to hospitals that compete at the same functional level with drug stores are subject to the Robinson-Patman Act.

Federal Trade Commission v. *Sun Oil Company*, 371 U.S. 505, 520 (1963) held in construing the Robinson-Patman Act:

> "* * * Congress intended to assure, to the extent reasonably practicable, that businessmen at the same functional level would start on equal competitive footing so far as price is concerned."

The § 13c exemption does not protect hospital drug sale practices that compete at the same functional level, for when hospitals engage in retail selling to nonhospitalized customers they are then competing directly with drug stores. *Clairol Incorporated* v. *Federal Trade Commission*, 410 F.2d 647 (9th Cir. 1969).

Petitioners argue that 13c should be extended to include situations where there is direct competition between hospitals and drug stores. Otherwise, petitioners argue, there was no reason to pass 13c in the first instance. However, petitioners overlook that in 1938 it was believed by hospitals (and drug manufacturers too, apparently) that the 1936 Robinson-Patman Act had prohibited "special prices" to hospitals.[78]

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[78] H.R. 2161, 75th Cong., 3rd Sess. (1938), quoting letter from the President of the Hospital Bureau of Standards and Supplies. This letter was quoted in both House and Senate reports. See A12-13, 15, Res. Br. in Opp.).

There was also considerable debate—and still is to a degree—among the antitrust bar with respect to the precise scope of functional discounts which are allowable under Robinson-Patman.[79]

13c was meant to clarify this point with respect to hospital purchase for intrahospital use. But, it was never intended to countenance a mass invasion of the retail drug sale market by hospitals. Rather as the Senate report noted:[80]

> "The purpose of the Robinson-Patman Act, to prohibit price discrimination between purchasers in interstate commerce where competition would thereby be lessened, does not seem to apply as to eleemosynary institutions as they are not operated for profit. The act does forbid such favors as might be granted by sellers to such institutions."

Similarly the House report noted:[81]

> "The Robinson-Patman Act prohibits price discriminations between purchasers in interstate commerce . . . where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition.
>
> "The committee does not feel that the wholesome purpose of the Robinson-Patman Act will

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[79] Patman, Complete Guide to the Robinson-Patman Act 23-25; Edwards, The Price Discrimination Law, 286.

[80] S.R. 1769, 75th Cong., 3rd Sess., quoted A14-15, Res. Br. in Opp.

[81] Footnote 78.

> be interfered with by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act."

It seems clear that Congress had in mind the role traditionally occupied by hospitals, and not the form of business buccaneering which petitioner and AHA contemplate.

C. 13c exemption does not apply when a hospital does not use drugs, food, etc. for hospital uses.

Respondent should again mention—since petitioners repeatedly seek to cast us in the role of the heavy in some sort of imaginary anti-hospital drama—that respondent has never suggested what disposition a hospital should make of the drugs it acquires. This is an intrahospital affair. But *we are concerned when a hospital acquires drugs at a price which discriminates against drug stores and then chooses not to use them for a hospital purpose, but decides to conduct an operation which cannot be distinguished—save for location—from that conducted by a drug store pharmacy.* Such acquisition can only be regarded as unfair competition.

D. The house subcommittee agrees that 13c applies only to intrahospital uses — as did the court of appeals.

The House Subcommittee, which investigated this identical problem, concluded (House Report No. 1983, 90th Cong. 2d Sess. 78-79):

"The Nonprofit Institutions Act of 1938 is designed to afford immunity to private nonprofit institutions (like hospitals so organized), from the prohibitions of the Robinson-Patman Act to the extent the sales are for the non-profit institution's 'own use'. The Nonprofit Institutions Act does not apply to institutions organized for profit.

"When a profit or a nonprofit hospital purchases drugs for its 'own use', this purpose is for a different function, i.e., unit doses for hospitalized patients rather than for resale at the retail drug distribution level. In such 'own use' purchases, at least in the contemporary climate of drug distribution in the United States, the hospital is not thereafter competing with retail druggists, because of such functional difference. Conversely, when the drug sales are not for such hospital's 'own use', but rather for general consumer resales, the institution is competing with the retail druggist because it is functioning in a competitive sense just like a retail druggist.

"This same result occurs when a 'for-profit' health care institution buys drugs for its 'own use' on one hand, or retail drug sales on the other hand. The Robinson-Patman Act is concerned with the realities of competition, not labels. (Federal Trade Commission v. Simplicity Pattern Co., 360 U.S. 55 (1959)).

"There is no basis apparent from the record why the mandate of the Robinson-Patman Act should not be applied to discriminatory drug sales favoring nongovernmental institutional purchasers, profit or non-profit, to the extent there is prescription drug competition at the retail level

with disfavored retail druggists. Consumer interests are compromised by permitting drug price discrimination in the area because the retailers and consumers ultimately must pay higher drug prices as a form of economic subsidy to the drug supplier for the lower prices which that drug supplier charges the institutions.

"To be sure, there may be a gray area in determining where own-use purchases leave off and retail competition begins with the private institutional health-care purchaser. This gray area centers on so-called outpatient dispensing by health-care institutions. While the term 'out-patient' is not susceptible of one simple definition which embraces all hospitals, the following factors appear to apply:

"(1) An 'outpatient' is a person who, although receiving hospital services, is not a confined, hospitalized patient;

"(2) The outpatient, by virtue of not being hospitalized, presumably has the physical mobility to purchase prescription drugs from retail sources other than the hospital;

"(3) Hospital drug sales to physically mobile outpatients therefore should be recognized as straightforward retail sales in direct competition with any other retail druggists in the community. The outpatient may be a captive customer or patient of the institution for other health-care services, but because of mobility, the outpatient is capable of se-

curing his prescription needs in the community."[82]

The same point was succinctly put by Judge Merrill in this case when he stated (510 F.2d 486, 489):

"Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of inpatients or emergency patients. The purpose for which these supplies are purchased—the use to which they are to be put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer.

"The hospitals here are (quite properly) accommodating patients, staff and strangers with means whereby they can conveniently purchase for their use. The question is not whether the hospitals can continue to provide this useful community service. The question is whether in providing it they may acquire the drugs for such resale at an acquisition price that discriminates against local retail druggists. We hold that they may not."

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[82] Because the committee's findings, conclusions and recommendations concerning 13c were based on extensive hearings, including testimony of various petitioners' officials, this subsequent congressional interpretation, while not controlling, is persuasive as to its construction. *N.L.R.B.* v. *Bell Aerospace Company Division of Textron, Inc.*, — U.S. —, 94 S. Ct. 1757, 1762 (1974) and *Red Lion Broadcasting Co.* v. *Federal Communications Commission*, 395 U.S. 367, 380-381 (1969) stand for the analogous rule that legislation declaring intent of the earlier statute is entitled to great or significant weight.

E. Words are construed in their ordinary and usual sense.

Lincoln said in his First Inaugural Address (March 4, 1861, VI 171):

"The intention of the lawgiver is the law."

Similar statements have been made by this court on many occasions.[83] In deciphering this intent presumably words are used in their ordinary and usual sense, with the meaning commonly attributed to them.[84] Significance and effect should be given, if possible, to every word of the statute,[85] and the maxim "nonscitur a sociis' applied unless clearly inappropriate.[86] Plain words of the statute should control.[87] No clause, sentence or word is regarded as superfluous,

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[83] *Rathburn* v. *U. S.*, 355 U.S. 107, 109 (1957), reh. den. 355 U.S. 925 (1958).

[84] *Levy's Lessee* v. *McCartee*, 31 U.S. 102, 110 (1832); *Maillard* v. *Lawrence*, 57 U.S. 251, 260-261 (1853); *Malat* v. *Riddell*, 383 U.S. 569, 571 (1966); *Banks* v. *Chicago Grain Trimmers Assn.*, 390 U.S. 459, 465 (1968), reh. den. 391 U.S. 929 (1968).

[85] *Barnes* v. *The Railroads*, 84 U.S. 294, 302 (1872) ("The statute speaks its own construction"); *D. Ginsberg & Sons* v. *Popkin*, 285 U.S. 204, 208 (1932).

[86] *Jarecki* v. *G. D. Searle & Co.*, 367 U.S. 303, 307 (1961) (The word gathers meaning from the words around it.); *Neal* v. *Clark*, 95 U.S. 704 (1877); *First Nat. Bank & Trust Co.* v. *Beach*, 301 U.S. 435, 440-1 (1937).

Broom's Legal Maxims 450 states: "It is a rule laid down by Lord Bacon that copulatio verborum indicat acceptationem in eodem sensu—the coupling of words together shows that they are to be understood in the same sense. And where the meaning of any particular word is doubtful or obscure . . . the intention of the party who has made use of it may frequently be ascertained and carried into effect by looking at the adjoining words."

[87] *Gemsco, Inc.* v. *Walling*, 324 U.S. 244, 256 (1945).

void, or insignificant in the absence of a strong indication to the contrary.[88]

Applying these axiomatic rules to a statute as unmistakable and sharply chiseled as this leaves no doubt.

F. The word "use" and especially the words "for their own use" refer to consumption by the hospital—not for resale to others.

The noun "use", and particularly when used in conjunction with the word "own" connotes consumption (as the Court of Appeals has said)[89] by the person using it. It does not mean resale in its usual context. While the word has many secondary meanings, consumption by the user is its usual meaning. As stated by Chief Justice White (*Billings* v. *U. S.*, 32 U.S. 261, 281 [1913]):

> "The word 'use", as there employed, means more than the mere privilege of using which the owner enjoys, and relates to its primary signification, as defined by Webster: 'The act of employing anything or of applying it to one's service; the state of being so employed or applied.'"

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[88] *Washington Market Co.* v. *Hoffman*, 101 U.S. 112, 115-6 (1879).

[89] It has long been recognized that there is a clear distinction between use and resale. Wyclif (Neh. X 31) [1388] noted:

> "The puplis . . . that bryngen in thingis set to sale, and alle thingis to vss." (*XI Oxford Eng. Dicitonary* 468).

It was defined as (*Bridgeport Mach. Co.* v. *McKnab*, 136 Kan. 781, 18 P.2d 186, 187): "to make use of; to employ; to exhaust; to leave no capacity of force or use in."

Illustrations are:

> "to use a telephone; to use a saw and other tools; to use one's eyes; to use coal or eggs in cooking. (What is used often has been consumed: a used automobile; all the butter has been used." (*Random House Dictionary*, Unabr. 1966)

> "employment or usage resulting in, or such as to cause, impairment, wear, etc." (*XI Oxford English Dictionary* 469, [1961]).

> "employment causing wear; need to use (with for); manner of using; power of using (e.g., tongue, limb)." (Chambers, *20th Century Dictionary*, [1973]).

> "to consume, expend, or exhaust by use (often with up); as he has used up all his energy to smoke or chew tobacco." (*Webster's New 20th Century Dictionary*, Unabr. 2012 [1964]).

> "to expend the whole of, consume, often with up." (*Funk & Wagnalls Ency. College Dictionary*, [1968]).

Nicholson's classic (*Practical Builder* [1823]) avers that (420):

> "Plate-glass is the most beautiful glass made use of."[90]

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[90] It was held that a shoe repairer does not have "use" of leather soles and rubber heels which he placed on customers' shoes as contemplated by the taxing Statute. The rule was otherwise for hammers, awls, sewing machines and lasts which he "used" in making the repairs. *Revzan* v. *Nudelman*, 370 Ill. 180, 18 N.E.2d 219, 222.

A dentist who places a denture in the mouth of a patient was held not to "use" the denture. *Berry-Kofron Dental Laboratory Co.* v. *Smith*, 345 Mo. 922, 138 S.W.2d 452, 455.

The 1921 Act 11 and 12 Geo. V c 21, § 4 states: "A per-

The words "used" and "consumed" in a statute giving a lien to the furnisher of material, machinery, fuel or lumber used or consumed on public improvements were held to be synonymous, as the word "used" meant "used up." *Osgood Co.* v. *Peterson Const. Co.*, 231 Wis. 541, 286 N.W. 54, 57 (1939).

Under the Use Tax laws the tax is not imposed if the article is one which will be resold.[91] Under the explicit terms of the use tax in several states, use is equated with consumption.[92]

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son registered . . . shall be entitled to take and use the description of dentist or dental practitioner."

It was held that one who re-recorded a record onto another record and then sold the re-recording was not using the record unless he played it. *Liberty US, Inc.* v. *Eastern Tape Corp.*, 11 N.C. App. 20, 180 S.E.2d 414, 418.

[91] *P. H. Mallen Co.* v. *Department of Finance*, 372 Ill. 598, 25 N.E.2d 43, 44 (1939); *G. S. Lyon & Sons Lumber & Mfg. Co.* v. *Department of Revenue*, 23 Ill. 2d 180, 177 N.E.2d 316, 318-319 (1961); *Dain Mfg. Co. of Iowa* v. *Iowa State Tax Commission*, 237 Iowa 531, 22 N.W.2d 786, 789 (1946); *Granite City Steel Co.* v. *Department of Revenue*, 30 Ill. 2d 552, 198 N.E.2d 507, 512 (1964); *Douglas Aircraft Co., Inc.* v. *Johnson*, 13 Cal. 2d 545, 557, 90 P.2d 572, 576 (1939); *Hawley* v. *Johnson*, 58 Cal. App. 2d 232, 136 P.2d 638, 641 (1943); *Hervey* v. *Southern Wooden Box, Inc.*, 253 Ark. 290, 486 S.W.2d 65, 68 (1972); *Herman M. Brown Co.* v. *Johnson*, 248 Iowa 1143, 82 N.W.2d 134, 143-4, supp. opin. 248 Iowa 1158, 84 N.W.2d 44 (1957).

[92] The State Tax Guide of Commerce Clearing House, Chapter 60, notes that the following states provide that the use tax "is imposed on the storage, *use or other consumption* . . .": California, Maine, Nebraska, Nevada, Ohio, Oklahoma, Rhode Island, Utah, Wisconsin and Wyoming.

In the following states there is an express exemption from the use tax for articles which are to be resold: Indiana, Louisiana, Minnesota, Missouri, New York, Oklahoma, Pennsylvania, Texas, Utah, Vermont, West Virginia.

In many states the terms use and consumption seem to be virtually interchangeable (i.e., the use tax is imposed on the "storage, use or consumption"): Alabama, Arkansas, Arizona, Colorado, District of Columbia, Kansas, Maryland, Massachusetts, Michigan, Mississippi, New Jersey, North

In 1878 the William Astor family spent the summer touring Europe, where they acquired a number of clothes. Some they wore in Europe. Others they packed in trunks for use during the approaching "season". Their homecoming was dampened by the New York customs inspector, who levied a $1880 customs duty. An exemption was provided for (Rev. Statutes [2d ed] 489 § 2505):

> "Wearing apparel in actual use and other personal effects (not merchandise) . . . of persons arriving in the United States. But this exemption shall not be construed to include machinery, or other articles imported for use in any manufacturing establishment, or for sale."

It was held that the exemption applied even though some of the clothes had not been actually worn, if they were (*Astor* v. *Merritt*, 111 U.S. 202, 212 [1884]):

> ". . . brought with him as a passenger, and intended for the use or wear of himself or his family who accompanied him as passengers, and not for sale, or purchased or imported for other persons, or to be given away . . ."

G. Supplies normally connote things intended for use by the person supplied and not for a subsequent resale.

Similarly, the word "supplies" does not normally mean resale.

Dakota, South Carolina, South Dakota, Virginia.

In the state of Washington the use tax is levied "for the privilege of using within the state, as a consumer, tangible personal property. . . ."

In many other states there is no use tax.

A supply wagon was never the same as the vendor's cart. Supply in a military sense includes (Random House Dictionary of the English Language, Unab. [1966]):

> "all items necessary for the equipment, maintenance, and operation of a military command, including food, clothing, arms, ammunition, fuel, materials and machinery."

A more general definition of supply is (2 Britannica World Language Dictionary, 1261 [1959]):

> "to furnish with what is needed; to supply an army with ammunition."

The case at bar deals with drugs. However, the language of 13c is "supplies", not drugs. Necessarily the same question would arise with respect to food, etc.

Would petitioners seriously contend that if a hospital decided to sell milk, bread or whatever on a regular basis to its employees, physicians or the general public indiscriminately, or open a retail store downtown in competition with A & P, it should be permitted to buy such products from the farmers at discrimintary prices on the pretext they were "their supplies for their own use"?

H. 13c does not apply to purchases for subsequent resale.

In addition to "use" and "supplies", Congress made its intent manifest by using the word "their" twice, and further stressed the point by inserting

"own" ("their supplies for their own use"). Petitioners propose to strike all four words.

There is only one possible point of reference for the words "their" and "own"—i.e., the hospital. Not drop ins, staff doctors or employees who take the drugs home for their personal use of themselves or their family or friends. Rather, as Judge Merrill has said (510 F.2d 486, 489):

> "The purpose for which these are purchased—the use to which they are put—is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer."

The 13c exemption is intended to be used to provide hospital care for needy sick. One consuming drugs at home is not receiving hospital care.

When the bill which became 13c was reported to Congress, both Senate and House committees quoted an identical letter from John Hayes, President of the Hospital Bureau of Standards and Supplies (Pet's Br. 38-39, 41). Mr. Hayes asked for the 13c exemption on the grounds the hospitals needed it to provide "foodstuffs and supplies for the care of the needy sick" and because "(t)he needy sick must be cared for . . ." Otherwise, he insisted, "many hospitals may have to close their doors".

Mr. Hayes was referring to hospital care.

As used by Mr. Hayes "care" is a noun meaning treatment in the hospital. Care in this context nor-

mally connotes "charge; protection; custody; as, he was under the care of a physician" *(Webster's New 20th Century Dictionary*, Unabr., 2d ed. [1965]).

What hospital care is being extended to a nonhospitalized drop-in nonpatient, a mail order customer, or an employee or physician or their families who consume the drug, food, etc., at their own homes, and some of whom may not be ill at all?[93]

II. Other Legal Authorities Are in Accord With the Ninth Circuit

Petitioners cite only two cases which bear directly on 13c.

The first was discussed in the opinion below as follows (510 F.2d 486, 490):

> "In this respect our case is similar to Students Book Co. v. Washington Law Book Co., 98 US App 49, 232 F 2d 49, 50-51 n 5 (1955), cert den 350 US 988 (1956), where the 13c issue was disposed of in a footnote. The plaintiff, a retailer seller of law books, complained of the defendant's sales at lower prices of books to campus bookstores at law schools. The distinction drawn by the court was similar to the one we draw here—between sales of books to universities for their own use, i.e., for their libraries, and sales to university-connected book stores for resale to students."

[93] The Hospital Bureau of Standards and Supplies which proposed 13c has since changed its name to Hospital Bureau. It was founded in 1910 as a *(Encyclopedia of Associations)*:

> ". . . national group purchasing organization for cooperative buying of hospital supplies and equipment."

It was not organized as a vehicle to sanction general commercial sales by hospitals to nonhospitalized persons.

Judge Bazelon, who wrote the *Student Book* opinion, also dissented in part. However, his dissent dealt with an issue irrelevant to this case and 13c—i.e., whether the jury should have been given an expanded definition of consignment. In making the statement quoted above he spoke for the entire court.

The second, *Logan Lanes, Inc.* v. *Brunswick*, 378 F.2d 212 (9th Cir.), cert. den. 389 U.S. 898 (1967), is from the same circuit which decided this case. In *Logan Lanes*, Utah State University purchased Brunswick bowling lanes and related equipment for permanent installation in its Student Union Building. After it was installed it was used by students of the University's physical education classes along with faculty and staff. On occasions some members of the public also used the lanes.[94] In our case the court below distinguished *Logan Lanes* as follows (510 F.2d 486, 489):

> "Logan Lanes, Inc. v. Brunswick Corp., supra, does not require the contrary result. There the alleged discriminatory pricing was for bowling alley equipment sold to a state university. The lanes had been acquired for use in connection with the university's physical education program and for recreation use of faculty, staff and students and were operated for those purposes. They were not, however, closed to the

[94] According to an affidavit submitted by Brunswick 124,415 lines were bowled from 1964-1966 by students, faculty, staff and guests, while 2,934 were bowled by others. According to affidavits submited by Logan Lanes, no effort was made to determine whether prospective customers were associated with the University.

general public and some public use (the extent was disputed) was made of them. We held:

'The primary purpose of the purchases established beyond dispute, was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff. This being the case, any additional use of the bowling facilities by the general public for a fee, even if such use is substantial, would not establish that the purchases were not made for the use of the University.'

"378 F.2d at 16. The university's public use was indeed in competition with other local alleys, and it may be questioned whether the university should not, in all fairness, have been compelled to choose between the public use and the favorable exemption. But that is not what the statute requires. It requires only that the 'supplies' be acquired by the university for its own use. It does not say that once acquired and put to that use they cannot then be used for any other purpose.

"Our case does not involve the acquisition of plant equipment. It involves acquisition of stores of supplies. Plant equipment acquired for a university's own use cannot be segregated from that acquired for use by others, since the same equipment serves both uses. In the case of stores of supplies acquired for consumption the situation is otherwise. Supplies that are resold can readily be segregated from those devoted to a hospital's own use."

We submit, this logic cannot be faulted.

The language of 13c is "purchases of their supplies for their own use." Necessarily the situation must be judged by that at acquisition—i.e., the purchase. When acquired—and at all times thereafter—Utah State fully intended to use the lanes itself, and did so. The fact that later it did not stop a few outsiders from using the lanes too in no way alters the original intent. The lanes were not divisible.

In *Logan Lanes* the court defined the word supplies as (1c 216):

". . . anything required to meet the institution's need . . ."

The primary definition of need is (Webster's 7th New Collegiate Dictionary 565 (1969)):

"A condition requiring supply or relief; (syn) need implies urgency and may suggest distress."

Under what logic could drugs, foods, etc., which a hospital buys for resale to nonhospitalized persons for their private use at locations remote from the hospital, be regarded as items needed by the hospital for the hospital's own use?

Other distinctions between this case and *Logan Lanes* are capsulated on pages A19-24 of Respondent's Brief in Opposition to Certiorari. There are others.

III. Congressional Purpose Will Be Frustrated if Hospitals Are Permitted to Obtain Drugs at Discriminatory Prices for Nonhospital Uses

The hospital trade association, which persuaded Congress to pass 13c in 1938, did so by convincing Congress the exemption was needed by nonprofit hospitals "because of the charitable nature of their work" "so that they might be able to provide" foodstuffs and supplies for the care of the needy sick because, the association argued,[95]

> "The needy sick must be cared for and such a development would throw an almost impossible additional burden on the Federal, State, and municipal institutions."

Subsequent to the passage of 13c, the charity extended by hospitals has been largely eliminated. More and more these charges are being absorbed by Medicare, Medicaid, OEO, medical welfare (state, federal and local) and various insurance programs, not to mention various federal and state grants for construction and other purposes.[96] As stated in one of the cases cited most conspicuously by petitioners and AHA *(Eastern Kentucky Welfare Rights Organization* v. *Simon* [D.C. Cir. 1972] 506 F.2d 1278, 1288, cert. granted May 19, 1975):

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[95] Pet. Br. 39.

[96] Hearings, supra, 55, 287. (The government will soon be paying approximately one-half its citizens' pharmaceutical bills under Medicare, state, local programs, etc.); R. 473; Desrosiers 18; Fawkes (2nd) 21; Ferrell 14; Hastings 11; Hollowell 9-10; Johnston 43; Matlick 21, 23; Slick 9; Sperry 21; Knowles, The Hospital, *Scientific American* (Sept. 1972) 128, 135.

> "The institution of Medicare and Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below cost hospital services. Much of that decrease has been realized since the promulgation of Revenue Ruling 56-185. Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay. Thus, it appears that the rationale upon which the limited definition of 'charitable' was predicated has largely disappeared."[97]

Quite a few of the hospitals,[98] including at least one in Portland, no longer accept indigent patients,[99] while more than once the state has been overcharged for welfare patients.[100] Two Portland hospitals will

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[97] This court has noted the same trend in *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250, 265 (1974).

Professor William Thomas stated:

> "The image of a voluntary institution as a charitable organization, financing its care of patients to a substantial degree through philanthropy . . . is largely anachronistic." *Hearings on Conditions and Problems of the Nation's Nursing Homes, Subcommittee on Long Term Care*, Spec. Committee on Aging, U.S. Senate, 89th Cong., 1st Sess., Pt. 2 (February 15, 1965) p. 559.

A survey of 2558 emergency room patients at Barnes Hospital in St. Louis reveals that only 9.1% were not covered by Medicare, Medicaid, Blue Cross, Blue Shield, or some other type of coverage. Perkoff and Anderson, Relationship between Demographic Characteristics, Patient's Chief Complaint, and Medical Care Destination in an Emergency Room, *VIII Medical Care* (July-Aug. 1970) 309, 319.

[98] *Memorial Hospital* v. *Maricopa County*, supra; *Eastern Kentucky Welfare* v. *Simon*, supra.

[99] R. 688-9 (except emergencies); cf. R. 809.

[100] R. 550, 810, 811, 939.

not accept drug prescriptions from welfare patients.[101]

The extent to which hospitals have moved away from the concept of charity for the "needy sick" is seen in one of the articles cited by AHA. It appears in *Hospitals* magazine for September, 1942 (four years after 13c was passed). It states (Martin, Control of Out-Patient Services and Charges, *Hospitals*, 85, 86):

> "The needy sick we shall always have, and they are definitely a charge and responsibility of the government. Their care and treatment both as out-patients and in-patients should be borne to a large degree by local, state or federal payments."

Is it not incongruous for hospitals, having obtained the passage of 13c assertely to provide "care" for the "needy sick" but which have largely forsaken charity, to now assert that 13c should be distended so that they can provide drugs at bargain prices to staff doctors, employees, and other nonhospitalized persons while often charging the full rate to in-patients, and in the process obliterate the neighborhood taxpaying pharmacies?

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[101] Shu[illegible] 19; McConnell 34.

Attached to the back of the brief is a chart showing sales at 14 Portland hospitals, which petitioners accept as accurate. It reflects drug sales by the hospitals for the period of $32,792,997, and net profits of $10,155,165. The average net profit on drug sales was 38.68% for the 13 hospitals for which profit data was available. Two hospitals reported annual net income from overall operations in excess of $1 million (R. 557).

IV. History

Few, if any, hospital drug sales to nonhospitalized patients were made at the time of the passage of 13c in 1938. Normally statutes are construed with reference to the circumstances which existed at time of passage. Statutes are not "modified" except by the enacting body.

Petitioners placed nothing in the record as to hospital drug distribution practices in 1938, the year 13c was passed.

Appendices VIII, IX and X at A43 et. seq. of the *Brief for Respondent in Opposition* establish that hospital drug sales for uses outside the hospital are a post-1938 development throughout the Northwest.

Petitioners' brief counters with a few scattered literary references to some early day outpatient clinics in other locations. These are, of course, far cries from the 1,000,000 plus prescription sales to non-hospitalized persons at Portland's Kaiser Hospital, etc.

The situation in the Northwest is not atypical of the US generally. In 1932 no more than 1500 of the 7000 U.S. hospitals employed full-time pharmacists (A45-46). As late as 1964 less than one-half had pharmacists who could fill prescriptions (A46).

Petitioners assert that 13c should be enlarged because today hospitals make many more sales to non-patients for outside use than they did in 1938.

This Court has repeatedly rejected statutory expansion by judicial fiat. *Gulf Oil Corp.* v. *Copp Paving Co.*, — U.S. —, 95 S.Ct. 392, 402 (1974).

Fortnightly Corporation v. United Artists Television, Inc., 392 U.S. 390, 401-402 (1968) held:

> "We have been invited by the Solicitor General in an *amicus curiae* brief to render a compromise decision in this case that would, it is said, accommodate various competing considerations of copyright, communications, and antitrust policy. We decline the invitation. That job is for Congress. *We take the Copyright Act of 1909 as we find it.* With due regard to changing technology, we hold that petitioner did not under that law 'perform' the respondent's copyrighted works." (fns. omitted) (Emphasis added).

Since at least 1879 this Court has held that statutes are construed with reference to the circumstances existing at the time of passage.[102]

Mobile & Ohio RR Company v. *Tennessee*, 153 U.S. 486, 502 (1894) held:

> "Legislative contracts, especially, should be read in the light of the public policy entertained, and the purposes sought to be accomplished at the time they were made, rather than at a later period when different ideas and theories may prevail. * * *"[103]

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[102] *Platt* v. *Union Pacific RR Co.*, 99 U.S. 48, 60 (1879).

[103] Other decisions holding that statutes are construed with reference to the circumstances existing at time of passage include: *United States* v. *Smith*, 197 U.S. 386 (1905); *United States* v. *Wise*, 370 U.S. 405, 411 (1962); *Civil Aeronautics Board* v. *Delta Air Lines, Inc.*, 367 U.S. 316, 323 (1961); *United States* v. *Champlin Rfg. Co.*, 341 U.S. 290, 297 (1951); *United States* v. *Rothberg*, 480 F.2d 534, 535 (2d Cir. 1973), cert. den. 414 U.S. 856; *Husted* v. *Consumers Power Co.*, 376 Mich. 41, 54, 135 N.W.2d 370, 375-376 (1965).

The Court has held that while old laws apply to changed conditions, a changed condition does not repeal the law.

V. Take-Home Drugs Are Not Covered by the 13c Exemption Since Not Intended for the Hospital's Own Use

There is nothing in the record to support petitioners' claim that many discharged bed patients are physically unable to secure drugs from commercial pharmacies after discharge (Pet. Br. 14, 26).

Petitioners' protests that the hospitals are protecting the patient are belied by two uncontradicted depositions (Carlson, Pye) that the respective hospitals compelled purchase of "take-home" drugs despite the expressed wishes of the captive purchasers to obtain the prescriptions from their drug stores.

Critically ill patients are seldom discharged from hospitals.

Persons who require care after hospital discharge normally are:

(1) transferred to convalescent or nursing homes; or

(2) receive care from friends and members of their families or from visiting nurses.

There is nothing in the record to support petitioners' alarm that discharged patients cannot rely on the capacity or willingness of neighborhood pharmacies (Pet. Br. 25).

Most patients are discharged from hospitals during daylight hours while retail pharmacies remain open as late as 10:00 p.m.[104]

Respondent's drug store assignors and other neighborhood pharmacies provide prescription delivery service (Meek's Rexall Powell Pharmacy), mail order service (Mt. Scott Pharmacy) and seven-day-a-week, 24-hour after-hours emergency service.[105]

An ambulatory patient (Pet. Br. 25) is, by definition, physically mobile and thus capable of securing his prescription needs in the community; he is not dependent on the hospital for his drug needs.

"Take-home" drugs for departing patients are frequently for the profit of the hospitals, and only nominally for the convenience of the patient.

VI. Employee and Physician Drug Purchases for Their Personal or Family Use at Home Are Not Supplies Used by the Hospital

The Court of Appeals ruling does not interfere with the privilege of hospital employees and physicians to obtain drugs at huge discounts from the much higher prices the hospitals charge unprivileged and captive patients.

The hospitals can continue to sell drugs to their employees and staff at any price as a "fringe" bene-

[104] Matlick 20.
[105] R. 646; Portland Telephone directory 851-2 (1975).

fit. Collective bargaining agreements are not affected.

Petitioners confuse the discount purchase "privilege" which hospitals have chosen to give their employees and staff physicians with the exemption granted the hospitals as institutions.

The exemption belongs to the hospital, and then only for purchase of "their supplies for their own use," not the employees of physicians.

Hospital employees and physicians are ambulatory. They could, if they wished, buy their drugs in the community.

The opinion does not take away "the privilege of purchasing drugs at the hospital pharmacy" (Pet. Br. 29).

All the opinion means as to the hospitals is that the hospitals will pay the same regular trade price as drug stores on drugs resold by the hospitals to employees and physicians, who are not patients themselves.

VII. The Standard Enunciated by the Court of Appeals Is Logical and in Keeping With the Express Language of 13c. It Can Also Be Administered With Ease

Petitioners and AHA importune that the 13c exemption should be distorted to encompass virtually every hospital purchase because the alternative would require segregated drugkeeping or bookkeeping.

Aside from the obvious irrelevancy of this tack, the premise is not correct either, because:

(1) Petitioners can satisfy the law by simply reducing their prices to drug stores to a comparable level charged hospitals for items sold to hospitals not intended for hospital use. If so, there would be no change in hospital prices and no need for segregation.

(2) All drugs sold for extrahospital use now are assigned a prescription number under applicable law, while those used intrahospital are not numbered and are called hospital orders.[106] Hospitals can determine the numbers and amounts of drugs which leave the hospital by checking their prescription records.

(3) In many hospitals today, the outpatient pharmacy is distinct and apart from the inpatient pharmacy.[107] In such cases there should be no problem whatever.

(4) Certain drugs—notably narcotics—are normally separated from other drugs now.[108] There is no indication that this is an onerous task.

(5) Petitioners maintain large numbers of detailmen, who frequent hospitals and attempt to keep

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[106] R. 716; see ftn. 44; Fawkes (2nd) 15; Zeasas 8-9.

[107] 31% of all short-term hospitals having 500 or more beds have an outpatient pharmacy, which is entirely separate from the regular hospital pharmacy. (Francke, Latiolais, Francke & Ho, *Mirror to Hospital Pharmacy*, 118 [1964]).

[108] Clarke, Medications for Outpatients; Operating a Successful Dispensary, *20 Hospitals* (October 1946) 60, 61.

close tabs on the drug needs of their hospital customers by checking stocks, etc., [109] and submit periodic reports to their employers.[110] It should be relatively easy to approximate the percentage not required for hospital needs.

(6) Petitioners have appealed from only a part of the 9th Circuit ruling. Thus, some bookkeeping segregation will be needed anyway.

(7) At the House Subcommittee hearing, the same questioin was presented to Earl Kintner, former FTC Chairman. Mr. Kintner testified that a similar separation is made (Hearings, supra 1c 20-21):

> "In many other areas of America, where a buyer purchases in more than one capacity, say as a retailer and as a wholesaler, that proportion of his business which is wholesale usually receives a better price than that portion of his business which is retail. This is a common way of complying with the Robinson-Patman Act, and it is understood by American businessmen generally."
>
> "MR. POTVIN: 'In fact, sir, are there not many industries such as the automotive parts industry, in which the credit-memo debit-memo manner of handling the split function has been a part of the landscape for several decades?"
>
> "MR. KINTNER: 'You are quite correct, Mr. Counsel. This is to my knowledge technically

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[109] Bremner 23; Coffee 38; Connerty 43; DeLong 63; Eldien 12; Haas 12; Kobelin 47; McClintic 89; Mason 89; Winther 10.

[110] Mason 44; Metz 115.

true in the automotive parts industry and in the gasoline refining business."

As to petitioners' assertion of alleged difficulty in determining the aliquot part used for hospital uses from that which is not, Mr. Kintner described such argument as (Hearings, supra 1c 27):

> "... an old chestnut. The businessman says, 'Well, I can't send my accountant in to audit his books.' Well, of course, he can't and he shouldn't. And he needn't do an extreme amount of policing that would absolutely, beyond peradventure, indicate how much of the business is at one function and how much at another function.
>
> "But businessmen do not operate in a vacuum. They have a certain amount of information available to them from trade sources. They are able to estimate, with a fair degree of accuracy, how much of a particular business is done at one function and how much is done at another, without going into the intimate details of a business operation as an internal revenue agent might. Minimally, they could rely upon what the buyer represents to them, and only question if they have good reason to question."

(7) For years quite a number of drug manufacturers, as a precondition to obtaining a preferential price, have required assurances from hospitals that the drugs be used exclusively for the hospitals' own use.[111] Petitioner Eli Lilly, for example, makes its

[111] R. 530 (A. H. Robins); Fawkes Ex. 9 (Carter-Wallace); R. 656. (The Sandoz agreement requires the hospital on preferentially priced drugs to dispense such drugs "exclusively within the confines of the purchasing institution.")

hospital customers sign an agreement that reads (Fawkes Ex. 8):

> "This account represents that it is a non-profit organization (tax-exempt hospital or tax-supported institution) and that purchases made under this agreement are for its *own use within the institution and are not for resale.*" (Underlining supplied).

Some petitioners print labels on products sold to hospitals on favored terms, such as "Hospital Use Only" or "This Package For In-Hospital Use Only".[112] Are such labels only empty gestures? Are they not acknowledging, by doing so, the distinction between a hospital use, and a use by a private individual at some location other than the hospital though the drug, for a time, may have rested on the shelf of some hospital pharmacy?

Many insurance policies and Medicare pay for drugs only where used in the hospital, and not elsewhere.[113] A bookkeeping bifurcation of hospital from non-hospital drugs occurs now to this extent.

VIII. Neighborhood Drug Store Pharmacies Should Be Preserved

While not overtly espousing the point, the unspoken premise for many of petitioners' arguments

[113] Department of Health, Education and Welfare, *"A Report to the President"*, (February 1967), 36.
Your Medicare Handbook, D.H.E.W. Publication No. (SSA) 73-10050, 9, 11, 20.

[112] R. 539, 872; See H.R. No. 1983, 90th Cong., 2d Sess. 58 (1968).

is that hospital pharmacies and pharmacists are inherently superior to their counterparts in drug stores.

The argument is irrelevant. It is also fallacious. Besides, we submit, if an economic judgment is to be made, it should be made by consumers under conditions of free and open competition. Neutral studies have also shown that approximately one in six or seven of all medications dispensed in hospitals is wrong.[114]

This issue has no real relationship, in our view, to the issue before the Court. At the same time we do not wish the Court to conclude that we agree with petitioners' contentions. For that reason we have attached in Appendix D, a discussion of some of the reasons showing that there are many values worth preserving in drug store pharmacies and that they are superior to hospital pharmacies in many respects.

IX. Destination of Hospital Profits Irrelevant

Petitioners' repeated reference to the fact that the hospitals' huge drug profits are used to support other activities within the hospital or plant expansioin (Pet. Br. 8-9) is irrelevant. The only live issue

[114] Ibid. fn. 41 at 262; Tester, William W., A Report of the Iowa Drug Distribution System, *Drug Intelligence*, 11 Nov. 1968, pp. 305-309; Stewart & Cluff, A Review of Medication Errors and Compliance in Ambulant Patients, *13 Clinical Pharmacology and Therapeutics* (July-August 1972) 463, 465; Barker & McConnell, How to Detect Medication Errors, *99 Modern Hospitals*, 95-106 (1962).

is whether the purchase of supplies for resale to nonhospitalized persons for use outside the hospital can fairly be regarded as hospital "supplies for their own use".

In any event the source of the profits, not the final destination of the profits, has been the controlling factor for years in the tax field in determining whether some activity is tax exempt. The fact that the profits generated from an unrelated business are used finally for the support or expansion of a tax-exempt hospital does not mean that the profits are tax exempt.[115] It is the use of the property and not the use of the proceeds derived therefrom which is determinative of the question of tax exemption. If this were not the law then virtually every druggist who makes contributions to his church could also claim tax exempt status too.

The Tax Reform Act of 1969, P.L. 91-172, inter alia, embodies the congressional intent that if tax-exempt organizations such as hospitals engage in commercial business in competition with taxpaying business, the tax-exempt organizations shall pay taxes on their unrelated business income. Thus, 26

[115] *Louise W. & Maud Hill Family Foundation* v. *United States* (Minn. 1972) 347 F. Supp. 1225, 1227; (see also *University Hill Foundation v. C. I. R.* (9th Cir 1971) 446 F.2d 701, 706, cert. den. 405 U.S. 965; *Bear Gulch Water Co. v. C.I.R.* (9th Cir. 1941) 116 F.2d 975, 977; *Umatilla County* v. *Sturtevant*, 9 Or. App. 55, 58, 495 P.2d 287, 288 (1972); *Sutter Hospital of Sacramento v. City of Sacramento*, 39 Cal. 2d 33, 244 P.2d 390, 394-395 (1952); *Cleveland Osteopathic Hospital v. Zangerle*, 153 Ohio St. 222, 91 N.E.2d 261, 264 (1950); *Oklahoma Tax Commission v. Sisters of Sorrowful Mother*, 186 Ok. 339, 97 P.2d 888, 893 (1939).

C.F.R. § 1.513-1, Definition of Unrelated Trade or Business, states in part:

> "* * * the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital and patients of the hospital in accordance with its exempt purposes . . ."

Two of the Portland hospitals have paid income tax on their drug generated nonpatient sales for some time.[116]

X. De minimis argument is not applicable here

Although petitioners at times have indicated they are not relying on the de minimis argument,[117] nevertheless it seems to be the unspoken premise for many of petitioners' arguments here.

Under no conceivable circumstance is it applicable here where the extent of hospital resales for nonhospital uses exceeded one million.[118]

Such defense is generally rejected anyway.[119]

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[116] R. 447.

[117] See p. 18, supra.

[118] See p. 19, supra.

[119] *Case-Swayne Co., Inc. v. Sunkist Growers*, 389 U.S. 384 (1967); *Maryland v. Wirtz*, 392 U.S. 183, 192-193 (1968); *Founding Church of Scientology v. United States*, 412 F.2d 1197, 1202 (Ct. Cl. 1969), cert. den. 397 U.S. 1009; *Fields v. United States*, 228 F.2d 544, 546-547 (4th Cir. 1955), cert. den. 350 U.S. 982; *Northern v. Nelson*, 448 F.2d 1266 (9th Cir. 1971); *National Labor Relations Board v. Suburban Lumber Co.*, 121 F.2d 829, 832 (3rd Cir. 1941); *Community Currency Exchange v. NLRB*, 471 F.2d 39, 42 (7th Cir. 1972).

CONCLUSION

The Court of Appeals Standard Is Legal and Practical

The Court of Appeals opinion creates a workable and fair standard for hospitals and their suppliers.

It upholds the express statutory purpose of the Robinson-Patman Act to protect competition.[120]

The 14 hospitals that resell drugs purchased at discount prices to persons for off-premises consumption are in direct competition with drug stores and are, necessarily, not using the drugs for their own use as the statute requires.

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[120] The Clayton Act had the support of all three parties when it was passed. The Robinson-Patman Act was passed in 1936 to plug certain loopholes which Congress felt existed in the Clayton and Sherman Acts (40 Cal. L.R. 526, 535 [1951]); H.R. No. 2287, 74th Cong. 2d Sess., p 6, (1936). Only 16 votes were recorded in opposition in the House of Representatives and none in the Senate. (Patman, *Complete Guide to the Robinson-Patman Act*, 10).

The House Committee on the Judiciary in 1956 made the following report:

> "Price discriminations favoring preferred buyers presented danger to the competitive enterprise system which is inconsistent with the policy of the price discrimination statute. Firms can abuse their superior market position and engage in discriminatory practices and eliminate small suppliers and small retailers from the competitive scene." (H. Rep. No. 2202, 84th Cong. 2d Sess., 1956).

The preceding year it was stated (Hearing on Price Discrimination Before the House Select Committee on Small Business, 84th Cong., 1st Sess., 1 at 631 [1955]):

> "The belief that price discrimination tends to be objectionable runs as a thread through all the history of economic thought on the effects of competition."

It was feared that if the Act is not enforced, then the only remaining alternative was direct government control and price fixing, which it was hoped could be avoided. (15 U. of Miami L.R. 225, 234 [1961]).

These 14 hospitals can continue to sell drugs to whomever they please, provided only that they cannot obtain drugs at discriminatory prices under the pretext that they are for the hospital's own use, when they are not to be so used.

Even petitioners and the district court recognize that the 13c exemption is limited.[121]

Petitioners further recognize the narrow scope of the exemption.

They do so by not appealing the Court of Appeals ruling that take-home refills and sales to walk-in members of the public, physicians for their office use and families of employees and physicians were outside the exemption.

Whether or not the Court of Appeals is affirmed or reversed, the hospitals and their suppliers must conform to the unappealed portion of the decision.

By their lack of protest or appeal the petitioners apparently concede that (1) the unappealed portions are correct as a matter of law and (2) do not impose any hardship or unworkable standard on the hospitals and petitioners.

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"THE COURT: I take it you'd have a different case if St. Vincents decided to acquire a chart—a fleet of fishing charter boats and supplied the dramamine for the charter boats' customers through one of its suppliers here.

"MR. CLARKE: That might be a different case, Your Honor. (Laughter.)

"I think you have approached the limit." (Tr. May 25, 1973, pp. 28-29)

There is nothing in the record or petitioners' brief to indicate why one part of the decision is unremarkable and the other creates difficulties.

Nothing in the record indicates that affirmance of the Court of Appeals will have an adverse effect on the care of persons receiving hospital, clinic or emergency treatment.

The decision does not limit the use of drugs. The physician, not the hospital, makes the decision on drug dispensing. That decision is based on therapeutic benefit, not the cost of the drug to the hospital or the patient.

Nothing in the record indicates that affirmance of the decision will have any adverse economic effect on hospitals.

Assuming (as petitioners claim), but not conceding, that only 10 per cent of hospital drug dispensing by volume is in dispute, 90 per cent of hospital drug purchases are unaffected by the decision.

Putting neighborhood pharmacies out of business, lessening competition and thus depriving the public of the ability to purchase drugs without the expense of travel to a hospital is a more serious matter than the minor impact on hospitals of complying with the law when they engage in retail trade.

The protection of competition, and therefore the public interest, is paramount under the Robinson-Patman Act.

The public interest is best served by fair, unsub-

sidized competition. Drug stores still sell more drugs than do hospitals—(though the percentages are closing rapidly).[122] Any who buy their drugs from such drug stores must necessarily pay more because the hospitals, and the doctors and employees who work there, are able to buy the same drugs at a discriminatorily lower price.

The workingman should not have to pay substantially more for drugs so that, for example, the physician may pay less.

Physicians do not need economic subsidies intended exclusively for the hospitals as institutions.

It is the consumer who pays for the practices struck down by the Court of Appeals, for as the House Small Business Committee concluded:

> "* * * Consumer interests are compromised by permitting drug price discrimination in the area, because the retailers and consumers ultimately must pay higher drug prices as a form of economic subsidy to the drug supplier for the lower prices which that drug supplier charges the institution." (Pet. Br. Opp. A6)[123]

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[122] R. 683.

[123] The State of California in 1968 passed the Crown Act (Chap. 1237, Statutes of 1968, § 14053.5, California Welfare and Institutions Code discussed at R. 122) which prohibits the charging of different prices to drug stores than to hospitals for drugs provided to Medi-Cal recipients. Medi-Cal is California's equivalent of the federal Medicare program.

Before its passage a Report of the Subcommittee on Health, Education and Welfare Services on Drug Prices, was issued by the Assembly Interim Committee on Ways and Means, California legislature, Assembly Interim Committee Report, 1965-67, Vol. 21, Number 18 (1c20):

Affirmance of the of the Court of Appeals will not hinder the nonprofit hospitals in the avowed reason for the exemption—care of the needy sick. That function — in the main — hospitals have managed since 1938 to shift to the taxpayer anyway; hence there is no need for judicial expansion of the § 13c exemption. But they cannot use the narrowly drawn exemption of 13c, which is limited to their supplies for their own use, to acquire drugs or other supplies at discriminatory prices, when they have no intent to use the same for or within the hospital.

Respectfully submitted,

ROGER TILBURY
HENRY KANE
Attorneys for Respondent

"The subcommittee recommends that the Legislature consider ways of eliminating the alleged multiple pricing practices of certain drug manufacturers, which inflates the wholesale costs of drugs to community pharmacies through which the vast majority of state pharmaceutical expenditures are channeled . . ."

"To the extent that such pharmacies are forced to pay higher prices for the products they later supply to Medi-Cal recipients, state pharmaceutical expenditures are thereby inflated."

OVERSIZE FOLDOUT(S) FOUND HERE IN THE PRINTED EDITION OF THIS VOLUME ARE FOUND FOLLOWING THE LAST PAGE OF TEXT IN THIS MICROFICHE EDITION.

SEE FOLDOUT NO 1-4